IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
WESTERN DIVISION
CIVIL ACTION NO. 5:05-CV-48-FL(1)

RICHARD P. NORDAN, as Ancillary Administrator for the separate Estates of STEPHEN S. HELVENSTON, MIKE R. TEAGUE, JERKO GERALD ZOVKO and WESLEY J. K. BATALONA,

Plaintiff,

v.

BLACKWATER SECURITY CONSULTING, LLC, a Delaware Limited Liability Company; BLACKWATER LODGE AND TRAINING CENTER, INC., a Delaware Corporation, JUSTIN L. McQUOWN, an individual; and THOMAS POWELL, an individual,

Defendants.

DECLARATION OF KEITH FLICKER

Keith Flicker, under penalty of perjury, states that the following is true and correct:

1. I am over the age of 18 and competent to testify. I have personal knowledge of all statements made herein.

2. I am a principal at the law firm of Flicker Garelick & Associates LLP, 45 Broadway, New York, New York 10006.

3. My practice is primarily concerned with issues related to the Longshoremen Harbor and Workers Compensation Act and the Defense Base Act. I have practiced in these areas for 25 years.

4. I have been retained by Blackwater Security Consulting with respect to the subject litigation.

5. In that capacity, I obtained copies of records maintained by the U.S. Department of Labor ("DOL") regarding Messrs. Helvenston, Teague, Zovko, and Batalona.

6. The attached copies of the following documents were received by me from the DOL pursuant to my request, are authentic copies of the documents received, are standard DOL forms, and are part of the public record:

A. *Zovko v. Blackwater Security Consulting*, Dept. of Labor Case No. 02-135369, Compensation Order, Award of Compensation (Oct. 8, 2004), Form LS-19a;

B. *In re Teague*, Dept. of Labor Memorandum of Informal Conference, Case No. 02-135368, (Feb. 25, 2005), Form LS-280;

C. Claim for Death Benefits by Dependents of Stephen S. Helvenston, Form LS-262;

D. Claim for Death Benefits by Dependents of Wesley K. Batalona, Form LS-262;

E. Compensation Without Award Form for Dependents of Michael Teague, Case No. 02-135368, Form LS-206

F. Compensation Without Award Form for Dependents of Stephen Helvenston, Case No. 02-135370, Form LS-206

G. Compensation Without Award Form for Wesley Batalona, Case No. 02-135371, Form LS-206.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. Executed on March 4, 2005.

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served the foregoing in the above-entitled action upon all other parties to this cause as follows:

Hand Delivered
David F. Kirby
William B. Bystrynski
Kirby & Holt, LLP
3201 Glenwood Avenue
Suite 100
Raleigh, North Carolina 276212
Attorneys for Plaintiff

U.S. Mail
Daniel J. Callahan
Brian J. McCormack
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Callahan & Blaine, APLC
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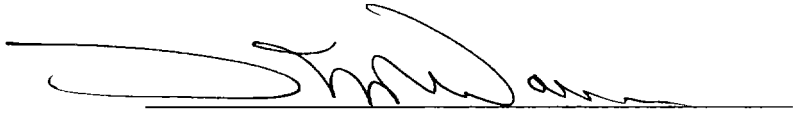
Powell & Goldstein, LLP
901 New York Avenue, NW
Third Floor
Washington, DC 20001-4413
Attorney for Defendant Justin McQuown

This the 7th day of March, 2005.



Kirk G. Warner

U.S. DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMPENSATION PROGRAMS
DIVISION OF LONGSHORE AND HARBOR WORKERS' COMPENSATION

Jerko Zovko (dec'd)
Claimant

v.

Blackwater Security Consulting
Employer

Fidelity & Casualty Co. of N.Y.
Insurance Carrier

COMPENSATION ORDER

AWARD OF COMPENSATION

CASE NO: 02-135369

ACT: DBA

IC: 2004 00190

Pursuant to agreement and stipulation by and between the interested parties and such further investigation in the above entitled claim having been made as is considered necessary, and no hearing having been applied for by any party in interest, or considered necessary by the District Director, the District Director makes the following:

FINDINGS OF FACT

1. That on, 3/31/2004 the claimant above-named was in the employ of the employer above-named at its premises in the Second Compensation District, established under the provisions of the Longshore and Harbor Workers' Compensation Act, as amended and extended; that the liability of the employer for compensation under the said Act was insured by Fidelity & Casualty Company of New York / CNA Global.

2. That on said day the claimant, while performing service as a employee for the employer, sustained injuries resulting in his death and that such death comes within the purview of the above ACT.

3. The requirement of notice of the injury to the employer has been met.

4. The employer furnished the claimant with medical treatment, etc.,in accordance with provisions of Section 7 of the said ACT.

5. The average weekly wage of the claimant at the time of injury is not an issue.

6. As a result of the death of the employee, the employer and the insurance carrier have made sufficient investigation to determine that the deceased has no dependents within the meaning of the Act.

Upon the foregoing findings of fact the District Director makes the following:

A W A R D

1. The employer/carrier shall pay the amount of $5000.00 to the Special Fund as provided for in Section 44 (c)(1) of the Act.

Given under my hand at 201 Varick Street
New York, New York 10014 this 18th day of October, 2004.

Richard V. Robilotti
District Director
2nd Compensation District

Ron Kucenski
Claims Examiner

CERTIFICATE OF FILING AND SERVICE

I certify that on October 18, 2004, the foregoing Compensation Order was filed in the Office of the District Director, Second Compensation District, and that a copy thereof was mailed on said date by certified mail to the parties and their representatives at the last known address of each as follows:

Estate of Jerko Zovko
105 Keewaydin Drive
Timberlake, OH 44095

Fidelity & Casualty Co. of N.Y.
CNA Global
333 South Wabash
32S
Chicago, IL 60685

Laughlin, Falbo, Levy & Moresi
39 Drumm Street
San Francisco CA 94111-4805

District Director,
Second Compensation District
U.S. Department of Labor
Office of Workers' Compensation Programs

If any compensation, payable under the terms of an award, is not paid within ten days after it becomes due, there shall be added to such unpaid compensation an amount equal to 20 percent thereof. The additional amount shall be paid at the same time as, but in addition to, such compensation.

The date compensation is due is the date the District Director files the decision or order in his office.

Form LS-19a

Memorandum of Informal Conference
(Under the Longshore and Harbor Workers' Compensation Act, As extended)

U.S. Department of Labor
Office Of Workers' Compensation
Post Office Box 249 NY, NY 10014-0249

1. Claimant:
Michael R Teague

* 2. OWCP File Number
* 02-135368

3. Employer:
Blackwater Security Consulting

* 4. Carrier/Employer's Number:
* 2004 00187

5. Insurance Carrier:
Continental Casualty Company

6. Date of Conference
02/25/2005

* 7. Date of Injury
* 03/31/2004

8. Appearances:

[ ] Claimant Present [X] Claimant not Present

For Claimant:
Nicholas Gianvito for Mrs. Michael Teague (natural mother)
Roger Levy for CNA/Employer
Donna Sprags for CNA
Keith Flicker for Employer

Issues: jurisdiction; payments to son

9. The claimant sustained/alleges an accidental injury on the date in item 7 while working for the above-named employer, under the circumstances bringing the injury within the purview of the LHWC Act(33 U.S.C 901 et seq.) or an extension there of resulting in the following injury(ies): died

10.Prior conferences were held on
the employer/carrier have paid compensation in the amount of $
for the following periods: benefits paid since death

11. Present Claim: CNA is paying widow benefits and benefits for son Brandon.

12. Employer/Carrier's Position: benefits paid

13. Average Weekly Wage (Sec.10)
$5276.00

* 14.Compensation rate(2/3 x AWW)
$1,047.00

[ ] As stipulated by parties
[ ] As recommended by examiner

Form LS-280

15. Claimant Died	*	16. Medical costs related to the injury
[ ] Returned to work on	*	☐ have been paid by the employer
[ ] Has not returned to work	*	
[ ] Did not lose time	*	☐ have not been paid

Upon discussion of the issues involved among those present, together with due consideration to all information in the administrative file, the following recommendation is made.

RECOMMENDATION

Compensation is to be paid as follows:

Defense Base Act is the proper jurisdiction.
Mrs. Rhonda Teague has sent check to Attorney Gianvito representing son's payment $259.00 for December, January, and February for $3,110.40.
Mrs. Rhonda Teague's attorney will submit letter regarding future payments for Brandon.

FEE

Approved Fee: $

A written application for fee for services rendered has been submitted and duly considered, and accordingly, the above fee (to include expenses) is approved in favor of:.

[ ] This fee is for an attorney and is made a lien on the compensation recommended.
[ ] There is no lien on the compensation.
[ ] The fee is to be assessed to the employer or carrier.

ACTION BY EMPLOYER/CARRIER

The self-insured employer or insurance carrier is to submit Form LS-206 or LS-208, showing compliance with the above recommendation. Upon completion of payment, a final Form LS-208 is to be submitted.

In the event of controversion, Form LS-207 is to be submitted.

To avoid statutory penalties all required forms should be sent to this office promptly and within the time requirements of the Act.

Richard V. Rebilotti
District Director
Phone#: (646)264-3010
frs

February 25, 2005
Date this Memorandum issued

Form LS-280

02-135370

Claim for Death Benefits

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

For Office Use Only	OWCP Number	Carrier's Number	OMB No. 1215-0160

1. Name of deceased employee (First, middle Initial, last): Stephen S Helvenston
a. Social Security Number (Required by Law):

2. Last address of last deceased (Number, street, city, state, ZIP)
line 1: 3903 Mesa Dr city: Oceanside
line 2: #106 st: CA zip: 92056

8. Place of Death: Iraq city: Fallujah st: zip:

9. Date of Death (mm/dd/yyyy): 03/31/04

3. Name and address of employer (Number, street, city, state, ZIP)
name: Blackwater
line 1: 850 Puddin Ridge city: Moyock
line 2: Road st: NC zip: 27958

10. Place where injury occured: Iraq city: Fallujah st: zip:

11. Date of Injury (mm/dd/yyyy): 03/31/04

4. Name and address of undertaker
name: Dale Miller
line 1: 914 W Main St city: Leesburg
line 2: st: FL zip: 34748

12. Nature of injury or occupational illness and cause of death (Give parts of body affected if Injured): Killed

5. Amount of undertaker's bill: 0
6. Amount Paid: 0

13. Name and address of last attending physician (or hospital)
name: V.A. Hospital
line 1:
line 2: city: San Diego st: CA zip:

7. Name of person paying undertaker's bill: N/A

14. ~~Widow or widower~~ X-wife

a. Full name and address
name: Patricia J. Isby
line 1: 3903 Mesa Dr city: Oceanside
line 2: #106 st: CA zip: 92056

b. Social Security Number (Required by Law): [redacted]
c. Date of birth (mm/dd/yyyy): [redacted]
d. Citizens: USA

e. Date married to deceased (mm/dd/yyyy): 08/13/1988
f. Place of marriage (City, State, Country) city: Virginia Beach st: CA country: USA
g. Signature of widow, widower, and/or guardian of children: Patricia Isby
Date (mm/dd/yyyy): 04/23/04

15. Children of deceased (see page 2 for qualification)

a. Full name	b. Address	c. Social Security Number (Required by Law)	d. Date of birth (mm/dd/yyyy)	e. Citizens
[redacted]	3903 Mesa Dr #106 city: Oceanside st: CA zip: 92056	[redacted]	[redacted]	USA
[redacted]	3903 Mesa Dr #106 city: Oceanside st: CA zip: 92056	[redacted]	[redacted]	USA
	city: st: zip:			

16. All other persons partially or wholly dependent on deceased for support (See page 2 for instructions)

	b. Income for one year preceding death: Source / Amount	c. Relationship	d. Age	e. Dependent: Wholly Pa
a. Full name and address name: line 1: city: line 2: st: zip: Signature Guardian? ☐ Date (mm/dd/yyyy)				☐
f. Full name and address name: line 1: city: line 2: st: zip: Signature Guardian? ☐ Date (mm/dd/yyyy)				☐

Important Notice

Section 31 (a)(1) of the Longshore Act, 33 U.S.C. 931 (a)(1), provides, as follows: Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed $1 0,000, by imprisonment not to exceed five years, or by both.

Form LS

Instructions:

1. Use this form to claim death benefits under the Longshore and Harbor Workers' Compensation Act, Defense Base Act, Outer Continental Shelf Lands Act, or Nonappropriated Fund Instrumentalities Act. The information provided will be used to determine entitlement to benefits.

2. Submit claim in duplicate to a district office of the Office of Workers' Compensation Programs (OWCP).

3. individual claims must be filed by or in behalf of each person eligible for benefits [33 U.S.C. 913(a)]. (included are grandchildren, brothers and sisters under 18 years, parents, step-parents, parents by adoption, parents-in-laws, and any person who for more than one year prior to the employee's death stood in place of a parent to him/her.)

4. Under item 16(b), state all your income for the year preceding death by source (Social Security pension, bonds, etc.) and amount. List separately support deceased furnished you, including the value of any shelter, food, clothing, or other supplies. Use space below or additional sheets if needed.

5. A person other than the claimant may complete claim for the beneficiary.

6. Persons are not required to respond to this collection of information unless it displays a currently valid OMB number.

Conditions of Eligibility

Coverage for Death Benefit

A death benefit is payable under the Longshore Act, or related law, if a covered employee dies as a result of work-related injury or occupational disease.

Who is eligible for a Death Benefit?

1. The deceased worker's widow or widower living with or dependent for support at the time of death; or widow or widower living apart for good cause or because of desertion by worker.

2. Unmarried child(ren) under age 18, or if over 18: (a) was (were) wholly dependent on deceased worker and unable to support self(ves) because of mental or physical disability, or (b) student(s) up to age 23 (must meet certain requirements). Includes a posthumous child, legally adopted child, child to whom deceased acted as parent for one year before injury, stepchild, or acknowledged illegitimate child.

3. If the combined amount due a surviving widow or widower and child or children is not greater than two-thirds (66 and 2/3 percent) of the worker's average weekly wages subject to a maximum benefit of 200 percent of the national average weekly wage, a benefit is payable for any one of the following: Grandchildren, brothers or sisters (if dependent at time of injury), parents, grandparents, or others satisfying legal requirements of dependency. (Consult the Office of Workers' Compensation Programs for more information.)

What terminates widow's or widower's benefits?

1. Death

2. Remarriage, in which case the widow or widower receives a lump sum payment of two year's compensation.

What evidence is needed to support a claim?

1. Widow or widower. Proof of marriage to deceased worker. If either party was married before, proof that earlier marriage was legally ended. A certified copy of the final divorce decree, or proof of death of a previous marriage partner may be required before benefits are paid. Certified copy of the death certificate of the deceased worker.

2. Children - Certified copy of birth certificate or Order of Adoption. If a legal guardian has been appointed, a certified copy of the Letters of Guardianship.

Time requirement of filing claim

Within one year of employee's death. The time may not begin to run, however, until the person claiming the benefit would reasonably have related the employee's death to his or her employment. In case of death due to an occupational disease, a claim may be filed within two years after the claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease and the death.

Use the space below or a separate sheet of paper to continue answers. Please number each answer to correspond to the number of the item being continued.

Privacy Act Notice

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a) you are hereby notified that (1) the Longshore and Harbor Workers' Compensation Act, as amended and extended (33 U.S.C. 901 et seq.) (LHWCA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the LHWCA. (3) Information may be given to the employer which employed the claimant at the time of injury, or to the insurance carrier or other entity which secured the employer's compensation liability. (4) Information may be given to physicians and other medical service providers for use in providing treatment or medical/vocational rehabilitation, making evaluations and for other purposes relating to the medical management of the claim. (5) Information may be given to the Department of Labor's Office of Administrative Law Judges (OALJ), or other person, board or organization, which is authorized or required to render decisions with respect to the claim or other matter arising in connection with the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the LHWCA, to etermine whether benefits are being or have been paid properly, and, where appropriate, to persue salary/administrative offset and debt collection actions required or permitted by law. Disclosure of the claimant's Social Security Number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN and other information maintained by the Office may be used for identification, and for other purposes authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim, the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: The notice applies to all forms requesting information that you might receive from the Office in connection with the processing and/or adjudication of the claim you filed under the LHWCA and related statutes.

Public Burden Statement

We estimate that it will take an average of 15 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C4315, 200 Constitution Avenue, N.W., Washington,DC 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE**

Certification of Funeral Expenses

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

The information provided on this form will be used to determine the amount of funeral expenses that are payable. Completion of the form is required to obtain payment for services performed (20 CFR § 702.121.) Persons are not required to respond to this collection of information unless it contains a currently valid OMB control number.

OMB No. 1215-0027
Expires: 04-30-05

For Office Use
1. OWCP No.
2. Carrier's No.

3. Name of deceased

First Name	M.I.	Last Name
Stephen	S	Helvenston

4. Funeral Director (Name, address, ZIP code)

name: Dale Miller
line 1: 914 W Main St
line 2:
city: Leesburg
state: FL zip: 34748
country: USA

5. **Services Performed**
(itemize below and enter costs)

Comments: Funeral home waived fees

Total Bill	0
Amount Paid	0
Amount Due	0

(If additional space is required continue on reverse)

6. I was informed that the above bill would be paid by — Enter name, address, and relationship to deceased.
name:
line 1:
line 2:
city:
state: zip:
relationship:
ctry:

7. This amount, $ 7559.26 of the bill was paid by — Enter name, address, and relationship to deceased.
name: Patricia Irby
line 1: 3803 Mesa Dr
line 2: #106
city: Oceanside
state: CA zip: 92056
relationship: x-wife
ctry: USA

Certification

I certify that this concern performed the above services and that no further part of this bill has been paid.

It is therefore requested that payment, in accordance with the Longshore and Harbor Workers' Compensation Act or its extensions, be paid for the services indicated above.

8. Signature and title (Type and sign)
Patricia Irby
name: Patricia Irby
title: x-wife
9. Date signed 4/23/04

Public Burden Statement

We estimate that it will take an average of 15 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210. DO NOT SEND COMPLETED FORMS TO THIS OFFICE.

Form LS-265
Rev. May 2002

Certification of Funeral Expenses

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

The information provided on this form will be used to determine the amount of funeral expenses that are payable. Completion of the form is required to obtain payment for services performed (20 CFR § 702.121.) Persons are not required to respond to this collection of information unless it contains a currently valid OMB control number.

OMB No. 1215-0027
Expires: 04-30-05

For Office Use
1. OWCP No.
2. Carrier's No.

3. Name of deceased

First Name: Stephen | M.I.: S | Last Name: Helvenston

4. Funeral Director (Name, address, ZIP code)

name: Dale Miller
line 1: 914 W Main St | city: Leesburg
line 2: | state: FL | zip: 34748 | country: USA

5. **Services Performed**
(itemize below and enter costs)

Comments: Funeral home waived fees

(If additional space is required continue on reverse)

Total Bill	0
Amount Paid	0
Amount Due	0

6. I was informed that the above bill would be paid by

Enter name, address, and relationship to deceased.
name:
line 1: | city:
line 2: | state: | zip: | relationship: | ctry:

7. This amount, $7559.76 of the bill was paid by

Enter name, address, and relationship to deceased.
name: Patricia Irby
line 1: 3803 Mesa Dr | city: Oceanside
line 2: #106 | state: CA | zip: 92056 | relationship: x-wife | ctry: USA

Certification

I certify that this concern performed the above services and that no further part of this bill has been paid.

It is therefore requested that payment, in accordance with the Longshore and Harbor Workers' Compensation Act or its extensions, be paid for the services indicated above.

8. Signature and title (Type and sign)
Patricia Irby
name: Patricia Irby
title: x-wife

9. Date signed: 4/23/04

Public Burden Statement

We estimate that it will take an average of 15 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210. DO NOT SEND COMPLETED FORMS TO THIS OFFICE.

Form LS-265
Rev. May 2002

02-135371

Claim for Death Benefits

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

1. Name of deceased employee (First, middle Initial, last): [illegible] JK Bellavia
a. Social Security Number (Required by Law): 575-72-2635
2. Last address of last deceased (Number, street, city, state, ZIP)
line 1: 43-961 Paauila Hwi Rd city: Paauila
line 2: st: HI zip: 96776
3. Name and address of employer (Number, street, city, state, ZIP)
name: Blackwater Security Consulting
line 1: 850 Pudden Ridge Dr city: Moyock
line 2: st: NC zip: 27958
4. Name and address of undertaker
name: Harry Dela
line 1: 179 Waianakia St city: Hilo
line 2: st: HI zip: 96720
5. Amount of undertaker's bill: 5695.85
6. Amount Paid: 5695.85
7. Name of person paying undertaker's bill: June Bellavia

For Office Use Only | OWCP Number | Carrier's Number | OMB No. 1215-0160

8. Place of Death
city: Fallujah st: Iraq zip:
9. Date of Death (mm/dd/yyyy): 3/31/04
10. Place where injury occured
city: st: zip:
11. Date of Injury (mm/dd/yyyy)
12. Nature of injury or occupational illness and cause of death (Give parts of body affected if injured)
Ballistic - Blast Injuries
13. Name and address of last attending physician (or hospital)
name:
line 1:
line 2:
city: st: zip:

14. Widow or widower
a. Full name and address
name: June Bellavia
line 1: 43-961 Paauila Hwi Rd
line 2: POB 171
city: Paauila st: HI zip: 96776
b. Social Security Number (Required by Law): [redacted]
c. Date of birth (mm/dd/yyyy): [redacted]
d. Citizenship: Yes
e. Date married to deceased (mm/dd/yyyy): 12-30-75
f. Place of marriage (City, State, Country)
city: Honolulu st: HI country: US
g. Signature of widow, widower, and/or guardian of children: June Bellavia
Date (mm/dd/yyyy):

15. Children of deceased (see page 2 for qualification)

a. Full name	b. Address	c. Social Security Number (Required by Law)	d. Date of birth (mm/dd/yyyy)	e. Citizenship
[redacted]	43-961 Paauila Hwi Rd city: Paauila st: HI zip: 96776	[redacted]	[redacted]	Yes
	city: st: zip:			
	city: st: zip:			

16. All other persons partially or wholly dependent on deceased for support (See page 2 for instructions)

a. Full name and address	b. Income for one year preceding death: Source	b. Income for one year preceding death: Amount	c. Relationship	d. Age	e. Dependent: Wholly	e. Dependent: Partially
name: line 1: line 2: city: st: zip: Signature Guardian? Date (mm/dd/yyyy)						
f. Full name and address name: line 1: line 2: city: st: zip: Signature Guardian? Date (mm/dd/yyyy)						

Important Notice

Section 31 (a)(1) of the Longshore Act, 33 U.S.C. 931 (a)(1), provides, as follows: Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed $ 10,000, by imprisonment not to exceed five years, or by both.

EXAMINED: U.S. DEPARTMENT OF LABOR DFWCP/DC MAR 10 2004

This Form Replaces Form LS-263 Which Is Obsolete

Form LS-262

CERTIFICATE OF DEATH (OVERSEAS)
Acte de décès (D'Outre-Mer)

NAME OF DECEASED (Last, First, Middle) Nom du décédé (Nom et prénoms) Batalona, Wesley-John, Kealoha	GRADE Grade	BRANCH OF SERVICE Arme Govt Civ	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale 575722638
ORGANIZATION Organisation Blackwater Security Consulting 850 Puddin Ridge Rd Moyock, NC 27958	NATION (e.g., United States) Pays USA	DATE OF BIRTH Date de naissance 20 Feb 1956	SEX Sexe ☑ MALE Masculin ☐ FEMALE Féminin

RACE Race	MARITAL STATUS État Civil	RELIGION Culte
☐ CAUCASOID Caucasique	☐ SINGLE Célibataire	☐ DIVORCED Divorcé
☐ NEGROID Negroide	☒ MARRIED Marié	☐ SEPARATED Séparé
☒ OTHER (Specify) Autre (Spécifier) Hawaiian	☐ WIDOWED Veuf	☒ PROTESTANT Protestant ☐ CATHOLIC Catholique ☐ JEWISH Juif ☐ OTHER (Specify) Autre (Spécifier)

NAME OF NEXT OF KIN Nom du plus proche parent June Batalona	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit Wife
STREET ADDRESS Domicile à (Rue) 43-961 Paauilo- Hui Road	CITY OR TOWN AND STATE (Include ZIP Code) Ville (Code postal compris) Paauilo, HI 96776

MEDICAL STATEMENT Déclaration médicale

CAUSE OF DEATH (Enter only once cause per line) Cause du décès (N'indiquer qu'une cause par ligne)		INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort[1]	Ballistic and blast injuries	Seconds
ANTECEDENT CAUSES — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire		
Symptômes précurseurs de la mort. — UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]		

MODE OF DEATH Condition de décès ☐ NATURAL Mort naturelle ☐ ACCIDENT Mort accidentelle ☐ SUICIDE Suicide ☒ HOMICIDE Homicide	AUTOPSY PERFORMED Autopsie effectuée ☑ YES Oui ☐ NO Non MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie NAME OF PATHOLOGIST Nom du pathologiste Louis N. Finelli, MAJ, MC, USA SIGNATURE Signature [signature] MAJ, MC DATE Date 06 Apr 2004	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures AVIATION ACCIDENT Accident d'Avion ☐ YES Oui ☑ NO Non

DATE OF DEATH (Hour, day, month, year) Date de décès (Heure, le jour, le mois, l'année) 1000, 31 Mar 2004	PLACE OF DEATH Lieu de décès Fallujah, Iraq

I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du dé funtet je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci-dessus.

NAME OF MEDICAL OFFICER Nom du médicin militaire ou du médicin sanitaire Louis N. Finelli	TITLE OR DEGREE Titre ou diplômé Deputy Medical Examiner	EXAMINED: U.S. DEPARTMENT OF LAB DLHWC – D.O. 2 MAY 10 2004 RONALD A. KUCENSKI, C.
GRADE Grade MAJ	INSTALLATION OR ADDRESS Installation ou adresse Dover AFB, DE 19902	
DATE Date 13 APR 04	SIGNATURE Signature [signature] MAJ, MC	

[1] State disease, injury or complication which caused death, but not mode of dying such as heart failure, etc.
[2] State conditions contributing to the death, but not related to the disease or condition causing death.
[1] Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc
[2] Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou e la condition qui a provoqué la mort.

Dodo Mortuary, Inc. - Hilo Branch

199 Wainaku St., Hilo, HI 96720- (808)935-5751

April 17, 2004 SERVICE NO. H04-0183

DECEASED NAME Wesley John Kealoha Batalona

DATE OF DEATH March 31, 2004 PLACE OF DEATH Fallujah, Iraq

a. for embalming you did not approve if you selected arrangements such as a direct cremation or immediate burial. If we charged for embalming, we will explain why below

STATEMENT OF FUNERAL GOODS AND SERVICES SELECTED

A. CHARGE FOR SERVICES:

Basic Services of Fun. Dir. & Staff	$ 750.00	
Embalming	$ -0-	
Other Preparation of the Body	$ -0-	
	$ -0-	
	$ -0-	
	$ -0-	
	$ -0-	
		$ 750.00
Visitation at Honokaa LDS Church	$ 300.00	
Funeral Service at Honokaa LDS	$ 350.00	
Memorial Service	$ -0-	
Other	$ -0-	
Cremation @ Dodo Mortuary	$ -0-	
		$ 650.00
Transfer of remains to Mortuary	$ 195.00	
(Hilo Airport to Mortuary)	$ -0-	
Funeral Coach	$ -0-	
(Mortuary to Honokaa LDS Ch to	$ 500.00	
Honokaa County Cemetery)	$ -0-	
Other	$ -0-	
	$ -0-	
	$ -0-	
		$ 695.00

B. CHARGES FOR MERCHANDISE:

Casket	$ 3,100.00	
Casket (Monterey Going Home Metal)		
Outer Container	$ -0-	
Outer Container		
Alternate Container	$ -0-	
Alternate Container		
Urn	$ -0-	
Other	$ -0-	
Other	$ -0-	
Other	$ -0-	
	$ -0-	
	$ -0-	
	$ -0-	
	$ -0-	
	$ -0-	
		$ 3100.00

be only warranty on the casket and/or outer burial container sold in connection with the service is the express written warranty, if any, provided by the manufacturer. This funeral home makes no warranty, express or implied, with respect to the casket and/or outer burial container.

To June Batalona
P.O. Box 171
Paauilo, HI 96776

C. SPECIAL CHARGES:

Forwarding of Remains to		
		$ -0-
Receiving of Remains from		
		$ -0-
Immediate Burial		$ -0-
Direct Cremation		$ -0-
Other		$ -0-
		$ -0-
		$ -0-

D. CASH ADVANCES:

Cemetery Charges	$ -0-
Grave Labor	$ -0-
Crematory Charges	$ -0-
Engraving of Urn	$ -0-
Refreshments	$ -0-
	$ -0-
	$ -0-
Other	$ -0-
Aloha Airline Chgs.	$ 206.05
(Honolulu to Hilo)	$ -0-
	$ -0-
	$ -0-
	$ -0-
	$ -0-
	$ -0-
	$ -0-

We charge you for our services in obtaining:

$ 206.05

SUMMARY OF CHARGES:

A. CHARGES FOR SERVICES	$ 2,095.00
B. CHARGES FOR MERCHANDISE	$ 3100.00
C. SPECIAL CHARGES	$ -0-
D. CASH ADVANCES	$ 206.05
E. SALES TAX, IF APPLICABLE	$ 207.80
TOTAL FUNERAL HOME CHARGES	$ 5608.85

LESS CREDIT AND PREPAYMENTS:

	$ -0-
	$ -0-
	$ -0-
	$ -0-
TOTAL CREDIT	$ -0-
BALANCE DUE	$ 5608.85

If any law, cemetery or crematory requirements have required the purchase of any of the items listed above the law or requirement is explained below.

Reason for Embalming

EXAMINED:
U.S. DEPARTMENT OF LA
DLHWC – D.O. 2
MAY 10 2004

I hereby agree that I have examined the above stated items and found them to be correct and according to the arrangements requested and I hereby acknowledge receipt of a copy of this memorandum and agreement. I hereby represent that I have sufficient funds and assets legally available for payment of cash price and hereby agree and covenant jointly and severally to make payments of $ 5608.85 within 10 days. A late charge of 1.5% per month amounting to 18% per year is applied to the unpaid balance beginning 30 days from the date of this agreement. Any additional services or merchandise ordered or requested after the date of this agreement will be considered part of this agreement and the cost thereof will be reflected on the final statement. I acknowledge that I have received the general price list and have been offered for review the casket price list and general price list.

Wife

Payment Of Compensation Without Award

(Longshore and Harbor Workers' Compensation Act, as extended)

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB No. 1215-0

NOTE: This Notice is to be filed with the Deputy Commissioner when the first payment is made. A copy should be sent to the person to whom compensation was paid. This report is required by law (33 U.S.C. 914(c). Failure to report may result in delays in the delivery of benefits.

FOR OFFICE USE

1. OWCP No. 02 135368

2. CARRIER'S No. 2004 00189

3. Name of injured person (First, middle, last - please print or type)
Michael Teague

4. Address of injured person (Number, street, city, state and ZIP code)
1229 Woodbridge Drive, Clarksville, TN 37042

5. Date of accident or first illness (Month, day, year)
March 31, 2004

6. Date disability began (Month, day, year)
N/A

7. Name of injured, or dependents of injured, to whom compensation will be paid
Rhonda Teague & [redacted]

8. Average weekly wage $ 5,278.00 multiplied by 2/3 = compensation rate $ 1,030,.78
(Mark if maximum rate is being paid) ☒ Yes

9. Compensation will be paid from - Enter month, day, year.
April 1, 2004
until notice is given that payment has been stopped or suspended

10. Date of first payment (Month, day, year.)
April 16, 2004

11. Has medical care and treatment been provided by a physician or hospital chosen by the injured person?
(Mark appropriate box) ☐ Yes ☐ No

12. Name of employer
Blackwater Security Consulting

EXAMINED:
U.S. DEPARTMENT OF LABOR
DLHWC - D.O. 2
JUN 14 2004
RONALD A. KUCENSKI, C.E.

13. Address of employer (Number, street, city, state and ZIP code)
1660 International Drive, Suite 470, McLean, VA 22102

14. Name of insurance carrier
The Fidelity & Casualty Company of New York/CNA Global

15. Authorized signature
Donna Sprags

16. Title of person whose signature appears in item 15
Casualty Claims Manager

17. Date signed
June 4, 2004

Public Burden Statement

We estimate that it will take an average of 15 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If yo have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Information Management, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0022), Washington, D.C. 2050

Form LS-206
Rev. Jan. 19-00

WC 8012c (Ed. 11-91) UNIFORM PRINTING &SUPPLY, INC.

Payment Of Compensation Without Award

(Longshore and Harbor Workers' Compensation Act, as extended)

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB No. 1215-00

NOTE: This Notice is to be filed with the Deputy Commissioner when the first payment is made. A copy should be sent to the person to whom compensation was paid. This report is required by law (33 U.S.C. 914(c). Failure to report may result in delays in the delivery of benefits.

FOR OFFICE USE

1. OWCP No. 02 135370

2. CARRIER'S No. 2004 00188

3. Name of injured person (First, middle, last - please print or type)
Stephen Helvenston

4. Address of injured person (Number, street, city, state and ZIP code)
P O Box 5526
Oceanside, CA 92052

5. Date of accident or first illness (Month, day, year)
March 31, 2004

6. Date disability began (Month, day, year)
N/A

7. Name of injured, or dependents of injured, to whom compensation will be paid
[redacted]

8.
Average weekly wage $ 5,278.00
multiplied by 2/3 = compensation rate $ 1,030.78
(Mark if maximum rate is being paid) ☒ Yes

9. Compensation will be paid from - Enter month, day, year.
April 1, 2004
until notice is given that payment has been stopped or suspended

10. Date of first payment (Month, day, year.)
April 26, 2004

11. Has medical care and treatment been provided by a physician or hospital chosen by the injured person?
(Mark appropriate box) ☒ Yes ☐ No

12. Name of employer
Blackwater Security Consulting

13. Address of employer (Number, street, city, state and ZIP code)
1660 International Drive, Suite 470, McLean, VA 22102

14. Name of insurance carrier
The Fidelity & Casualty Company of New York/CNA Global

15. Authorized signature
Donna Sprags

16. Title of person whose signature appears in item 15
Casualty Claims Manager

17. Date signed
April 30, 2004

Public Burden Statement

We estimate that it will take an average of 15 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Information Management, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0022), Washington, D.C. 20503

Form LS-206
Rev. Jan. 19-00

8012c (Ed. 11-91) UNIFORM, PRINTING &SUPPLY, INC.

Payment Of Compensation Without Award

(Longshore and Harbor Workers' Compensation Act, as extended)

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB No. 1215-00

NOTE: This Notice is to be filed with the Deputy Commissioner when the first payment is made. A copy should be sent to the person to whom compensation was paid. This report is required by law (33 U.S.C. 914(c). Failure to report may result in delays in the delivery of benefits.

FOR OFFICE USE

1. OWCP No. 02 135371

2. CARRIER'S No. 2004 00187

3. Name of injured person (First, middle, last - please print or type)
WESLEY BATALONA

4. Address of injured person (Number, street, city, state and ZIP code)
43-961 PAAUILO-HUI ROAD, PAUUILO, HAWAII 96776

5. Date of accident or first illness (Month, day, year)
MARCH 31, 2004

6. Date disability began (Month, day, year)

7. Name of injured, or dependents of injured, to whom compensation will be paid
JUNE BATALONA & [redacted]

8.
Average weekly wage $5,278.00
multiplied by 2/3 = compensation rate $1,030.78
(Mark if maximum rate is being paid) ☒ Yes

9. Compensation will be paid from - Enter month, day, year.
APRIL 1, 2004 until notice is given that payment has been stopped or suspended.

10. Date of first payment (Month, day, year.)
JUNE 17, 2004

11. Has medical care and treatment been provided by a physician or hospital chosen by the injured person?
(Mark appropriate box) ☒ Yes ☐ No

EXAMINED:
U.S. DEPARTMENT OF L
DLHWC - D.O. 2
JUL - 8 2004
RONALD A. KUCENSKI,

12. Name of employer
BLACKWATER SECURITY CONSULTING

13. Address of employer (Number, street, city, state and ZIP code)
850 PUDDIN RIDGE ROAD, MOYOCK, N C 27958

14. Name of insurance carrier
The FIDELITY & CASUALTY COMPANY OF NEW YORK/CNA GLOBAL

15. Authorized signature
DONNA SPRAGS

16. Title of person whose signature appears in item 15
CASUALTY CLAIMS MANAGER

17. Date signed
JUNE 25, 2004

Public Burden Statement

We estimate that it will take an average of 15 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If yo have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Information Management, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0022), Washington, D.C. 2050

Form LS-206
Rev. Jan. 19-00

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